APPENDIX A

SAMPLE
HEALTH CARE FORMS

www.kdhe.state.ks.us/c-f/special_needs_part2.html

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SAMPLE HEALTH CARE FORMS

It is recognized that each student's health care needs are unique. Therefore, it is important to determine, as part of the health care planning process, the extent of information and documentation required.

Following are sample forms to assist in the development of a student's Individualized Health Care Plan.

Individualized Health Care Plan
This provides a detailed summary of the student's health condition, the health care procedures to be provided, personnel responsible, identifying information and important contacts.

Anticipated Health Crisis Plan
Details the procedures to be followed and the personnel to be involved if or when an emergency occurs. The plan should always be attached to the Individualized Health Care Plan. A copy of this completed form should also be provided to all appropriate personnel.

Individualized Health Care Plan Checklist
A checklist to identify what health care activities and documentation has been completed for the student.

INDIVIDUALIZED HEALTH CARE PLAN[1]

Health History and Physical Assessment Information

NAME OF STUDENT_____ DATE OF BIRTH_____

PRESENT SCHOOL_____ GRADE_____

ADDRESS_____ PHONE_____

PRIMARY CARE PHYSICIAN_____
CURRENT PROBLEM/MEDICAL DIAGNOSIS_____
_____

PERSON(2) FILLING OUT FORM_____ DATE_____
Mother only [ ] Father Only [ ] Both [ ]
Other [ ] (please specify)_____
FATHER'S NAME_____ MOTHER'S NAME_____

EMERGENCY INFORMATION
Legal Custodian Phone_____ Other_____
PARENT RELATIONSHIP TO CHILD: NATURAL [ ] ADOPTED [ ]

LIVING WITH: BOTH PARENTS [ ] FATHER ONLY [ ] MOTHER ONLY [ ]

WHO ELSE LIVES WITH CHILD_____
MAJOR LANGUAGE IN HOME_____

FAMILY PHYSICIAN_____ DATE OF LAST PHYSICAL_____
INSURANCE INFORMATION

PRIMARY INSURANCE #_____ SECONDARY INSURANCE #_____

HEALTH HISTORY:

PREGNANCY AND BIRTH

PRENATAL:

- When this child was born, how old was mother?_____ father?_____
- Was this child born (1st, 2nd, 3rd, etc.)_____ of your children?
- How long was this pregnancy?_____ Was the baby born on time?_____
- What kind of problems (bleeding, cramping, etc.) or accidents happened during this pregnancy, if any?
  _____
- Did you take any medications while pregnant?_____
  What and why?_____
  _____
- What kinds of problems did you have with other pregnancies?_____
  _____

PERINATAL:

- How long was your labor?_____
- Were there any difficulties during the delivery?_____ What kinds?_____
  _____

- Did you have a Caesarean Section, or regular vaginal delivery, or forceps delivery?_____
- How long did mother stay in hospital after birth?_____
- Did the baby come home with mother?_____ If not, please explain._____
- Did baby need oxygen after birth? _____. Did baby turn yellow enough to be treated? _____

DEVELOPMENTAL HISTORY

• DEVELOPMENTAL LANDMARKS:

- At what age did your child:
  Begin to crawl?_____ Finish toilet training (bowel)?_____
  Begin to walk alone? _____ Finish toilet training (bladder)? _____
  Begin saying words (not mama or dada)?_____
- Did you or anyone else have serious concerns that your child was unusually small or short for age?
  Please explain. _____
- Has anyone else in your family been unusually small in size or short in stature? Please explain. _____

CURRENT HEALTH HABITS AND OTHER BEHAVIOR

- Does your child feed him/herself? _____ Does he/she have any problems eating certain foods?
  Good appetite or poor one? _____ Is he/she often hungry? _____
  Do you feel your child gets enough to eat? _____
- How much sleep does he/she get at night? _____ Naps? _____
- Does he/she dress him/herself well? _____ Does he/she pick out his/her own clothes? _____
  What does he/she need help with? _____
- Does he/she ever wet the bed anymore? _____ How often? _____
  When did he/she last wet the bed? _____
- Does he/she have any habits such as thumb sucking or nail biting? _____
- How much exercise does your child get? _____
- Is there anything he/she is now particularly afraid of? _____
  What is it? _____
- How much time do you think your child spends daydreaming? _____
- To your knowledge what kinds of experience has your child had with:
  alcohol _____
  drugs _____

PERSONALITY TRAITS

- Please indicate whether you think you child is generally:

☐ happy	or	☐ sad	other_____
☐ shy	or	☐ out-going	other_____
☐ generous	or	☐ jealous	other_____
☐ restless	or	☐ calm	other_____
☐ good-natured	or	☐ irritable	other_____
☐ kind to others	or	☐ unkind	other_____

- Does your child cry easily? _____ What makes him cry? _____

_____

- What kind of temper does your child have? _____
  What makes him lose his temper? _____
  What does he do when angry? _____

- Does your child make friends easily? _____
  Are his friends mostly his age, younger, or older? _____

- What does your child like to do for fun? _____

_____

  Does he prefer to play indoors or outdoors? _____

SIGNIFICANT HEALTH PROBLEMS, ILLNESS AND COMPLAINT

HEALTH PROBLEMS:

- Is your child under regular medical care for any condition? _____
  What is the condition? _____

_____

- Is he currently taking any medications? _____ What are they? _____

_____

  Does he have any side effects from them? _____ If so, what? _____

_____

- Does your child have any chronic problems such as:
  asthma? _____ allergies: _____ seizures(fits)? _____
  diabetes? _____ other? _____
- Is your child frequently ill with such things as:
  colds? _____ how often? _____
  ear infections? _____ how often? _____
  other? _____ how often? _____
  other? _____ how often? _____
- What physical or mental handicaps does your child have? _____

PAST PROBLEMS:

- What operations (surgery) has your child ever had, and when? _____

_____

_____. What injuries has he had that were serious enough for a doctor's care (stitches, casts, etc.) and when? _____

_____

- Has your child ever lost consciousness (knocked out), either from an injury or fainting? _____
  Please explain._____

FAMILY HEALTH HISTORY:

- Please list the names and ages of blood-relatives (immediate family) and what health problems each may have:

Name	Age	Relationship	Health Problems

- Has anyone else in the family (including parents) had any learning or other school problems?_____
  Please explain._____

CURRENT HEALTH CHECKLIST:

Please circle any of the following items that apply **now** to your child's health and explain details at the bottom:

ENT: Double vision, tearing, blurring, eye discharge, crossed eyes, colds, sore throats, earaches, stuffy nose, hearing, smelling, taste, mouth breathing, snoring, sneezing, nosebleeds, dental problems.

CARDIO RESPIRATORY: Shortness of breath, wheezing, coughing, chest pain, swelling, turning blue with exercise, cold hands or feet.

GASTRO INTESTINAL: Vomiting, diarrhea, constipation, abdominal pain, jaundice (yellow skin or eyes), bowel control, rectal bleeding, nausea, pinworm symptoms (itchy rectum).

GENITO URINAL: Urinates too frequently, pain, blood in urine, vaginal discharge, abnormal menstrual history, abnormalities of penis and testes, bladder control.

NEURO-MUSCULAR: Tingling, numbness, headaches, dizziness, seizures (fits), shaking, twitching, blackouts, problems with posture, deformities, gait, personality changes, unconsciousness, general speech.

SKIN: Itching, irritation, perspiration, growths, rash, excessive dryness, unusual skin color, nail or hair problems.

SUMMARY OF HEALTH HISTORY

NURSING EVALUATION

DATE_____ MEDICAL DIAGNOSIS:_____

NAME_____ BIRTH DATE_____ TEACHER/GRADE_____

A. PHYSICAL ASSESSMENT

GENERAL APPEARANCE:

_____

_____

_____

Height_____ Percentile_____
Weight_____ Percentile_____

Vision Acuity: R____ L____
Hearing Acuity: R____ L____

KEY TO INTERPRETATION

0 = Essentially Normal
1 = Slight Pathology
2 = Moderate Pathology
3 = Severe Pathology

HEAD

HAIR
____ Dry
____ Brittle
____ Course

SCALP
____ Nits
____ Flaky
____ Dry
____ Oily
____ Dandruff
____ Other

EYES

____ Strabismus
____ Exudate
____ Redness
____ Movement
____ Pupillary Reaction

EARS

EXTERNAL
____ Redness
____ Swelling
____ Tenderness
____ Drainage
INTERNAL
____ Wax-Amount
____ Color
____ c/o Pain

MOUTH & THROAT

____ Sores
____ Redness
____ Lymph Nodes
____ Teeth
____ Speech

SKIN

COLOR
____ Cyanosis
____ Ruddiness
____ Pallor
____ Jaundice
TEXTURE
____ Rough
____ Dry
____ Oily
____ Smooth
LESIONS
____ Rash
____ Acne
____ Cuts
____ Bruises
____ Scars

CHEST, LUNGS, HEART

____ TPR
____ BP
____ HR & Rhythm
____ Pulses
____ Breath Sounds

MUSCLE - SKELETAL

____ Spine
____ ROM
____ Posture

NEUROLOGICAL

GROSS MOTOR SKILLS
____ Balance on 1 foot
____ Hops
____ Skips
____ Jumps
____ Tandem walk
____ Catches ball
FINE MOTOR SKILLS
____ Finger to nose with eyes open
____ Finger to nose with eyes closed
____ Finger to thumb
____ Heel to shin

SUMMARY OF PHYSICAL ASSESSMENT

_____
_____
_____
_____
_____
_____
_____

B. NURSING CARE PLAN

NURSING PROBLEMS/DIAGNOSIS:

NURSING INTERVENTION AND RESPONSIBLE PERSONNEL:

NURSING EVALUATION OF INTERVENTIONS:

Anticipated Health Crisis

(Note: This should always be attached to the Individualized Health Care Plan)

Student's Name	Date
Physician	Phone
Medical Diagnosis	Preferred Hospital

STUDENT SPECIFIC CRISIS

IF YOU SEE THIS	DO THIS

IF AN EMERGENCY OCCURS

1. If the emergency is life-threatening, immediately call 9-1-1.
2. Stay with the student or designate another adult to do so.
3. Call or designate someone to call the principal and/or health care provider.
   a. State who you are
   b. State where you are
   c. State problem
4. If the nurse is unavailable, the following staff members are trained to deal with this anticipated health crisis and to initiate the appropriate procedures:

_____

_____

_____

_____

_____

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Individualized Health Care Plan Checklist

I. STUDENT INFORMATION

Name	Birthdate
Parent/Guardian	Address
Mother Home ( ) Work ( )	Father Home ( ) Work ( )
School	Grade

II. ACTIVITIES COMPLETED

[ ] Parent/Guardian Consultation Date _____

[ ] Health Care Assessment Date _____

[ ] Health Care Plan Meetings Date _____ Date _____ Date_____

[ ] Educational Planning (i.e., IEP or Section 504) Date _____ Date _____ Date _____

III. DOCUMENTATION COMPLETED

[ ] Referral Date_____

[ ] Physician's Order/Authorization Date_____

[ ] Medication/Treatment Record Date_____

[ ] Individualized Health Care Plan Date_____

[ ] Anticipated Health Crisis Plan Date_____

[ ] Personnel Training Plan Date_____

[ ] Transportation Plan Date_____

[ ] Student's special health care needs limited to medication only.

TO BE COMPLETED BY HEALTH CARE COORDINATOR/PROVIDER

Signature	Title

2

NOTES

1. Information on pages A-2 to A-6 of this section adapted from:

   Colorado Department of Public Health & Environment. (1995). *Procedure Guidelines for Health Care of Students with Special Needs in the School Setting.* (pp. 11-16 of Part I). Denver.

2. Information on pages A-8 and A-9 of this section adapted from:

   Montana Office of Public Instruction. (1993). *Serving Students with Special Health Care Needs: A Technical Assistance Document.* (Section X - Sample Health Care Forms). Helena.